

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gabriel Brogan, a prisoner at HMP Littlehey, on 30 January 2021

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Brogan died of pneumonia caused by Chronic Obstructive Pulmonary Disease (a lung condition that causes breathing difficulties) on 30 January 2021, while a prisoner at HMP Littlehey. He was 72 years old. We offer our condolences to Mr Brogan's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Brogan received at HMP Littlehey was equivalent to that which he could have expected to receive in the community.
5. The clinical reviewer said that Mr Brogan's long-term health conditions were managed to a good standard. However, she found that healthcare staff did not use National Early Warning Score 2 (NEWS2 – a tool used to detect acute illness) tool consistently, a matter we have raised in previous fatal incident investigations.
6. The clinical reviewer made one recommendation related to Mr Brogan's death, below. She made three further recommendations which were not directly related to Mr Brogan's death, but that the Head of Healthcare will need to address.
7. We did not identify any non-clinical issues of concern.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendations

- The Head of Healthcare should ensure that staff use the National Early Warning Score 2 (NEWS2) assessment tool and follow the recommended clinical escalation procedures.

Investigation Process

8. NHS England commissioned a clinical reviewer to review Mr Brogan's clinical care at HMP Littlehey. The clinical review is attached to this report at Annex 1.
9. The PPO investigator has investigated the non-clinical issues in Mr Brogan's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
10. The PPO family liaison officer wrote to Mr Brogan's family to explain our investigation. Mr Brogan's family asked a number of questions about Mr

Brogan's clinical care and the decline in his health which are addressed in this report and the clinical review. We have addressed his concerns about Mr Brogan's access to exercise during the COVID-19 pandemic in this report. The family also had concerns about reported problems with the prison's heating and hot water system, which have been addressed in the clinical review.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
12. Mr Brogan's family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly. Mr Brogan's family also raised a number of issues and questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Previous deaths at HMP Littlehey

13. Mr Brogan was the 22nd prisoner to die at Littlehey since January 2019. Twenty of the previous deaths were from natural causes (four of which were related to COVID-19). One of these deaths was self-inflicted and one remains unclassified. Since Mr Brogan died, there have been five natural cause deaths, four of these were related to COVID-19.
14. We have previously made three recommendations regarding the use of NEWS2 scores. On 20 June 2019 and 2 February 2020, the Head of Healthcare agreed and completed actions to ensure that all clinical staff consistently use and are aware of the triggers for escalation of care.

Key Events

15. On 12 December 2016, Mr Brogan was convicted of sexual offences and was sentenced to 16 years in prison four days later. He was sent to HMP Belmarsh for 10 months and then spent 9 months at HMP Isle of Wight. He was transferred to HMP Littlehey on 24 July 2018.
16. Mr Brogan had several health conditions including Chronic Obstructive Pulmonary Disease (COPD), high blood pressure and diabetes. Mr Brogan had lung cancer in 2012 and treatment to remove a tumour was successful. On 21 March 2020, Mr Brogan agreed to shield and was isolated in line with prison COVID-19 measures.
17. Due to COVID-19, there was a restricted regime and Mr Brogan's family were concerned about his access to exercise. The prison confirmed that he had access to the gym twice weekly and two one-hour sessions outside per day. This was in addition to collecting meals and included structured exercise sessions led by a Physical Education Instructor.
18. In August, a nurse noticed that Mr Brogan was short of breath and coughing. She referred him for an urgent GP review. Although the GP did not see him, Mr Brogan later said that he was feeling better when reviewed by a senior nurse. Blood tests were clear and Mr Brogan was scheduled for a review of his COPD.
19. On 31 December, Mr Brogan was admitted to Hinchingsbrooke hospital with breathing difficulties. He was diagnosed with a chest infection and was

discharged from hospital that evening with antibiotics. The clinical reviewer said that no clinical observations or a NEWS2 score were recorded until a nurse conducted a routine post-hospital review at lunchtime on 1 January.

20. On 2 January, Mr Brogan was sent to hospital by ambulance because his breathing difficulties continued to worsen. He was again admitted to Hinchingsbrooke Hospital. On 20 January, the hospital told the prison that Mr Brogan had double pneumonia. A prison family liaison officer was allocated on 25 January. The family liaison officer made contact with Mr Brogan's family on 30 January when the hospital told her that Mr Brogan had died.
21. Mr Brogan's condition deteriorated in hospital and on 30 January, he died of pneumonia caused by COPD.

Clinical Findings

22. The independent clinical reviewer concluded that the care that Mr Brogan received was equivalent to that he could have expected to receive in the community. The clinical reviewer was not satisfied that healthcare staff were consistent in their use of National Early Warning Score 2 (NEWS2- a tool to detect acute illness and deterioration) and made a recommendation accordingly. The clinical reviewer's full findings and additional recommendations are set out in her report at Annex 1.

Karen Johnson
Assistant Ombudsman

August 2021

Annexes

1. Clinical review
2. Action plan

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